MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09333

Reg. Diat. No. 251

1. PLACE OF DEATH:

County ~~Kent~~ Queen Anne's

City or town Chestertown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County ~~Kent~~ Queen Anne

City or town Chestertown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma Crew

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Leonard Crew

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug 25 1886

8. AGE: Years	Months	Days	If less than one day
61	1	7	....hrs. ....min.

9. Birthplace Kent Co

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Geo W. Sumpleen

13. Birthplace Pa

MOTHER

14. Maiden name Elizabeth Mc Guire

15. Birthplace Kent Co

16. Informant Leonard Crew

Address Chestertown R 1

17. Burial Date thereof Oct. 5-1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chestertown

Location Chestertown Md.

18. Funeral director Edgar L. Lane

Address Church Hill Md.

19. Oct. 3 1947 Edgar L. Lane

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1947 to Oct 2 1947

and that I last saw ~~him~~ her alive on Oct 2 1947

	DURATION
Immediate cause of death Coma	2 Days
Due to Diabetes Mellitus	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. G. Simpson M. D. or other

Address Chestertown Md Date signed 10-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09334

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County: Prince Georges

City or town: Rural Barclay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~1 day~~ 9 hrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: P. G.

City or town: Rural Barclay

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 9 - 1947

8. AGE: Years | Months | Days | If less than one day: 9 hrs. ..... min.

9. Birthplace: Rural Barclay Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Wm. Thos. Elborn

13. Birthplace: Md.

MOTHER 14. Maiden name: Elizabeth Foster

15. Birthplace: Md.

16. Informant: Mrs Wm T Elborn

Address: Barclay Md R.F.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10 1947 (month) (day) (year)

Cemetery or crematory: Templeville Md

Location: Templeville Md

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. ..... 19..... (Date rec'd by registrar) Edgar L Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Oct 10 1947 and that I last saw h.. alive on Oct 9 1947 @ 11:30 AM

Immediate cause of death	DURATION
Congenital heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Theodore F Lapsocki MD M. D. or other

Address: Galena Md Date signed: 10-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

The reason this certificate is dated 10-17- I had to return it to the Doctor- When he made out a new one he changed the date

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

09335

Reg. Dist. No. 252

1. PLACE OF DEATH:
County Queen Annes
City or town Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Annes
City or town Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Katie Goldsborough

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	Colored	Married

6.(b) Name of husband or wife: Charlie Goldsborough
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): December 12-1886

8. AGE: Years	Months	Days	If less than one day
60	9	24	...hrs. ...min.

9. Birthplace: Centreville Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
12. FATHER Name: Wesley Clayton
13. FATHER Birthplace: Centreville Maryland
14. MOTHER Maiden name: Alice P Likens
15. MOTHER Birthplace: Centreville Maryland
16. Informant: Anna Rozier
Address: Centreville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct-8-47 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville Maryland
18. Funeral director: Baxter Sons
Address: Centreville Maryland
19. 10-8-1947 Elsie Armstrong Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1947, at 10 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 4- 1947, to Oct 6- 1947
and that I last saw h... alive on Oct 5- 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: W. Henry Fisher M. D. or other
Address: Centreville Md Date signed 10/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

09336

CERTIFICATE OF DEATH

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Queen Anne

City or town: Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Chester
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Hines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife: Margaret Turner Hines

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1879

8. AGE: Years: 68 yrs. Months: Days: If less than one day: hrs. min.

9. Birthplace: Stevensville, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: Jacob Hines
13. Birthplace: Stevensville, Md.

MOTHER
14. Maiden name: Mary Hines
15. Birthplace: Stevensville, Md.

16. Informant: Henrietta Hill
Address: Chester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: rd. 7-47 (month) (day) (year)

Cemetery or crematory: Cemetary

Location: Stevensville md

18. Funeral director: Lewis a. Henry

Address: Cambridge Md

19. Oct 7 19 47 (Date rec'd by registrar) Elizabeth Hopkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 19 47 at 3:38A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 25 19 47 to October 3 19 47 and that I last saw him alive on October 3 19 47

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Renal Disease	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Howe, MD
M. D. or other

Address: Queenstown, Md Date signed: 10-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

09337

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:
County: Queen Annes
City or town: Rural Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Annes
City or town: Queenstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Floda Rebecca Hallins

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Reese C Hallins
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feby - 28 - 1878

8. AGE:

Years	Months	Days	If less than one day
69	7	4	hrs. min.

9. Birthplace: Phillips, W. Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Ellis Howell
13. Birthplace: Dont Know

MOTHER
14. Maiden name: Eliza P Killips
15. Birthplace: Dont Know

16. Informant: Reese C Hallins
Address: Queenstown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6-47 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville Maryland

18. Funeral director: Barton Bros
Address: Centreville Maryland

19. Oct 4 - 1947 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2 1947, at 6 a ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Found dead in bed. Evidently Heart attack.	
Due to	
Due to She was treated at J Hopkins Hosp in 1945 for Heart Trouble.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Henry Fisher
Deputy M.E. M. D. or other
Address: Centreville Md Date signed 10/3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09338

CERTIFICATE OF DEATH

Reg. Dist. No. 253

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Stevensville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nellie Kaveschaar | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Not known 1875
8. AGE: Years: about 72 | Months | Days | If less than one day: hrs. min.
9. Birthplace Budapest Hungary (Town, county, and state)
10. Usual occupation retired
11. Industry or business
FATHER 12. Name Not known
13. Birthplace "
MOTHER 14. Maiden name "
15. Birthplace "
16. Informant Frank A. Schwenke
Address Stevensville Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct 10-47 (month) (day) (year)
Cemetery or crematory HOLY CROSS CEM.
Location A. A. Co.
18. Funeral director Bernard E. Harle
Address 121 E West St
19. 10/8 1947 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 45

20. DATE OF DEATH October 7 1947 at 11 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7th 1947 to Oct 7 1947
and that I last saw h 4 alive on Oct. 7th 1947

	DURATION
Immediate cause of death: cerebral hemorrhage	Oct. 7. 1947.
Due to: Arteriosclerosis	Several years.
Due to:	
Other conditions: Amputation of Rt. foot last	10 years ago

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmaier M.D.
M. D. or other
Address Stevensville Date signed 10/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09339

CERTIFICATE OF DEATH

Reg. Dist. No. 254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Queen Anne

City or town: Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lawrence Franklin Morgan

3.(b) Social Security Number: 218-01-0900

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Goldie Mae Morgan

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 26, 1886

8. AGE: Years	Months	Days	If less than one day
61	2	13	hrs. min.

9. Birthplace: Rural, Centreville, Queen Anne, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Ice Plant

FATHER 12. Name: Robert E. Morgan

FATHER 13. Birthplace: Centreville, Maryland.

MOTHER 14. Maiden name: Ella Virginia Collison

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Goldie Mae Morgan

Address: Queenstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11 '47 (month) (day) (year)

Cemetery or crematory: Chesterfield

Location: Centreville

18. Funeral director: Barton Bros.

Address: Centreville, Md

19. Oct. 9 1947 H. M. Aldridge Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1947 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 1947 to October 7 1947 and that I last saw him alive on October 7 1947

Immediate cause of death	DURATION
Coronary Thrombosis	5 min.
Due to	
Due to	
Other conditions: Fever of Undetermined Origin	4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Crane, M.D. M. D. or other

Address: Queenstown, Md. Date signed: 10-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(168) 69340

Reg. Dist. No. 254

1. PLACE OF DEATH:

County: Queen Anne's

City or town: Grasonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Grasonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Lewis Daniel Webster Pierson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 10, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	26	..... hrs. ..... min.

9. Birthplace: Grasonville, Queen Anne's, Md (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER — 12. Name: Clifton Pierson

FATHER — 13. Birthplace: Do not know

MOTHER — 14. Maiden name: Sally Woolford Pierson

MOTHER — 15. Birthplace: ? Maryland

16. Informant: Mr. Carroll Pierson

Address: Grasonville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9-47 (month) (day) (year)

Cemetery or crematory: Chesterfield

Location: Centreville Maryland

18. Funeral director: Baxter Bros

Address: Centreville, Maryland

19. Oct. 9. 1947 (Date rec'd by registrar) Helen M Aldridge Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1947 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1946 to October 1947

and that I last saw h.. alive on October 6 1947

	DURATION
Immediate cause of death: Pneumonia, lobar, left lower	3 days
Due to: Arteriosclerotic Cardiovascular Disease	
Due to:	
Other conditions: Fracture of rt. femur (Accident Sept. 1946)	14 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Crane, MD (M. D. or other)

Address: Queenstown, Md Date signed: 10-7-47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09341

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Starkeys Corner
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Q. A.
City or town: Starkeys Corner
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Etta Elnora Starkey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married

6.(b) Name of husband or wife: James Starkey
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): April 19-1879

8. AGE: Years	Months	Days	If less than one day
68	6	6	hrs. min.

9. Birthplace: Queen Anne Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas Chaires
13. Birthplace: Md.

MOTHER
14. Maiden name: Mollie Reed
15. Birthplace: Md.

16. Informant: Mrs. Carl Starkey
Address: Centreville Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28-1947 (month) (day) (year)
Cemetery or crematory: Centreville
Location: Centreville Md.

18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. Oct. 26 1947 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1947 at 8.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1937 to Oct 25 1947 and that I last saw h.. alive on Oct 23 1947

	DURATION
Immediate cause of death: Coma any cerebral	10 min.
Due to: Generalized arter Sclerosis	years
Due to:	
Other conditions: Repeated cerebral Coma by disease	1939

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.: none
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A K Layton M. D. or other
Address: Centreville Md. Date signed: 10-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15